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Creating Partnerships in Health Care: A Local Initiative

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Introduction

As this nation enters 1992, one may characterize the time period as the best and the worst of times. Our nation not only faces a deep economic recession; it also faces a greater challenge in dealing with a health care system diagnosed as critical. Although this nation spends more of its GNP for health care than any other, we still find millions of Americans unable to afford and receive adequate care. There are locations within the United States where the infant mortality rate is higher than some third world countries.

In the 1980s we have seen significant changes in health care programs and in reimbursement. As a result of such changes, health maintenance organizations and preferred patient organizations have come into being. Reimbursements to hospitals for care and treatment have forced many hospitals to change the way they must now do business. Many hospitals have closed their doors and others will continue to do so because of lack of cash flow. This nation also faces a lack of medical personnel—doctors, nurses and other allied health specialists—to deliver the needed medical care. Federal programs have shifted more and more responsibility for funding to the states where resources are also limited and under stress. Obviously this nation will be searching to find the right mix of public and private medical insurance to help finance a medical care system that includes the 37 million uninsured. The state of health care in rural areas is no less critical. Problems found there are often many times greater than in the nation as a whole.

The following papers were written not for policymakers in Washington or policymakers at state government. This publication was written for local leaders. Local governments and local leaders will probably be forced to accept more responsibility for their local health care system just as the states have. The authors encourage you to utilize this information as a backdrop and foundation for movement on the issues faced in the health care arena.

Local leaders must become active policymakers at the local level to insure an adequate health care system for constituents. Local leaders both in and outside the health area must not become advocates for any special health interests. They must work to find ways to integrate a fragmented system. Local leaders must be willing to engage policymakers at the state and federal levels of government to create partnerships for success. Being able to work at both horizontal and vertical levels of community will be an important ingredient in the final outcome.

All of us probably see the health care system in a shadow of despair, but remember behind this shadow is light. We must focus on the light for guidance. Rural health care is in a state of crisis, but out of crisis comes innovation. These are the best of times because it offers us the opportunity to see the light and make innovative changes to make a better health care system.

Richard Reinheimer
Subcommittee chair
Rationale for Health Programming

In rural areas of the country the lack of access to health care, including accurate and current information needed to promote health and prevent disease, is a well recognized problem. The consequences of substantial numbers of rural residents being unable to obtain timely and adequate health care can be seen in the high rates of mortality and morbidity due to potentially preventable disease and disability. The injury, death and disability rates among those employed in agriculture remain among the highest of all occupations.

National and state efforts to attract, support and retain adequate numbers of physicians and allied health professionals in rural areas have met with limited long-term success. Further, resources to support public health professionals in these counties have been scarce. Thus, improvement in the health status of rural residents has become a community-wide issue. Access to and the provision of adequate health care, including health promotion, are dependent on a broad range of inputs from community leaders and residents for the development of new and innovative intervention strategies. The Cooperative Extension Service is increasingly recognizing its capacity for health promotion. Traditional extension activities, such as promotion of safe pesticide use and adequate nutrition, have long served to promote health and prevent illness and injury. However, many extension agents are broadening the scope of their programs to directly address a variety of rural health needs. They are building health programming into the Agency's system of outreach, education and community activities.

Initiating Health Programs

Five steps in initiating or implementing extension health programs are outlined here. Two through four have been used as successive steps to establish health programs through the Georgia Cooperative Extension Service. The ultimate success has been in those programs where extension agents have moved gradually from extension health-related community programs to one-on-one working relationships with community health professionals and finally on to community-wide coalitions. This has allowed extension agents to gain credibility and to establish themselves as having a legitimate role in the larger public health arena. The steps are:

1) Document Health-Related Needs. It is often helpful for extension agents to establish that needs exist before beginning a health program. A health assessment can justify extension initiatives to coworkers, other agencies, and local residents. The health assessment is also useful in determining what segment of the population is at highest risk for death and disability, the characteristics of the individuals affected, and their location within the county. The state or county health department may have a formal community assessment system in place which can be drawn upon. This is based primarily on statistics provided by the state vital statistics office, but the information can be enhanced through interviews with health and human service providers and community members. The extension agent's documentation of need does not preclude local residents, or a community health coalition, from conducting a health assessment once they become involved.

2) Establish Extension as a Health-Related Resource. There are many health and health-related activities an extension agent can conduct alone. These include programs on stress management, nutrition, exercise/fitness, weight reduction, and injury prevention. When working alone, extension agents should be careful not to undertake activities which require health or medical training they do not
have. This concern can be alleviated by collaborating with a health professional.

3) Collaborate with Health Professionals. Extension agents can increase their health promotion capacity and credibility by collaborating with one or more local health professionals. It is from health and health-related organizations that extension’s health programs will draw much of their content and support. Conversely, the strength of extension programs in accessing community needs, recruiting volunteers, and facilitating programs are often recognized by other agencies. This mutual appreciation can become the basis of joint programming. It can lead to joint projects in areas such as cholesterol, hypertension, and diabetes screenings, health fairs, and volunteer training programs.

4) Form or Join Health Coalition. Extension agents can also increase their ability to promote health by forming or joining a county or community coalition of health and health-related professionals. A community coalition can identify unmet health needs and help pool local resources to meet those needs. Extension-Health Agency collaboration often forms the nucleus of a community-wide group. This nucleus can then be broadened to include social workers, teachers, clergy and civic leaders. It is important to identify the concerns and encourage participation among low income and minority populations that generally have the greatest health needs. This can be done by seeing that these populations have strong representation within the coalition.

5) Seek Additional Training. Finally, extension agents can enhance their ability to plan and facilitate health promotion by seeking out additional education in the health field. This continuing education could include health-related workshops or classes at a local college or university.

An example of how the North Carolina Cooperative Extension Service’s Rural Health Program is working with counties to address some of the health promotion needs of rural residents is described here.

The Community Health Advocacy Program

Local extension and health department personnel are joining with other county agencies and community residents to initiate the Community Health Advocacy Program (CHAP) throughout North Carolina. CHAP trains natural leaders from diverse socioeconomic backgrounds to disseminate information on health and health resources and to initiate health-related projects in their communities. This lay-advisor approach of delivering health information is so similar to traditional extension program models that it is seen as appropriate for adoption and adaptation as part of the extension health program.

The North Carolina Cooperative Extension Service’s Rural Health Program received a grant in June 1990 from the Kate B. Reynolds Trust to train CHAP Coordinators for forty counties. CHAP was first developed at East Carolina University (ECU) by Walter Shepherd and was inaugurated in nine counties between 1984 and 1989, most often under the auspices of County Health Departments. Linda Loud from the Center for Health Services Research and Development at ECU is now responsible for the ECU-CHAP component; Barbara Garland and Steve Derhick, Rural Health Program Specialists from the North Carolina Cooperative Extension Service (NCCES), are responsible for implementation of CHAP through NCCES. The Health Promotion Section, located in the Division of Adult Health in the North Carolina Department of Environment, Health, and Natural Resources, serves as a program co-sponsor.

Program implementation begins with a three-day Coordinator Workshop for county extension agents (usually home economists) and county health department representatives (usually a health educator) who collaborate as CHAP Co-Coordinators. The Coordinator Workshop focuses on coalition building, community assessment, health program planning, group dynamics and adult education methods.

At the workshop, co-coordinators receive a CHAP Development Guide designed to help them plan, implement and support the program in their counties. The guide contains information about CHAP and the development process, as well as standard letters, forms, and agendas. The development guide is not meant to be used as a cookbook but rather as a tool to help coordinators adapt CHAP according to local needs and resources.
After the workshop and upon their return to their respective counties, the CHAP co-coordinators will organize a Steering Committee of five to seven individuals representing other county agencies and organizations. The task of the Steering Committee is to identify communities with both the need for and interest in beginning a CHAP program.

Once communities are identified, the co-coordinators establish an Advisory Committee made up of a broad spectrum of community residents in order to increase community ownership and decision making. The Advisory Committee is responsible for selecting health advocates for the CHAP training. The most critical step of the program is the selection of Health Advocates who are already recognized as natural helpers and advisors by members of their communities. In order to identify such people, CHAP co-coordinators ask residents, "Who in your community do you, or would you, go to for help or advice?" Where several Health Advocates are to work in an area, one person is selected as the community coordinator to facilitate communication between the Health Advocates and the co-coordinators.

Health and health-related professionals, including medical and emergency personnel, are recruited to provide basic health training in a three-hour a week, twelve-week Health Advocate Training Course. Training focuses on methods of health promotion and disease prevention concerning substance abuse, teen pregnancy, family violence, chronic diseases, mental health, home and farm safety. Methods for looking at a community and assessing health program needs are included. Co-coordinators supplement this information through quarterly continuing education sessions held for the advocates. The cost of materials for local training programs are obtained from local civic and other community organizations wherever possible. These costs consist mainly of the CHAP Manuals furnished each advocate and the cost of CPR training.

After receiving training, Health Advocates become available to the individuals in their community as sources of current and accurate information on health promotion and referrals. They are also encouraged to assist in determining community health program needs and strategies for meeting them. CHAP co-coordinators continue to provide support and technical assistance to the health advocates through inservice training and ongoing dialogue. Contact is also maintained through a CHAP newsletter. The implementation and focus of CHAP varies according to local needs and resources. Across North Carolina, county CHAP programs are addressing a wide range of issues including infant mortality reduction, teen pregnancy prevention, worksite health and the health of the elderly.

The program contributes to rural health and community development in several ways:

1) health and health-related agencies are working together more closely;

2) county extension agents are gaining knowledge necessary for successful health programming;

3) individual health advocates are acquiring and sharing useful health information; and,

4) members of rural communities are gaining access to health information and resources hitherto not available to them.

In building such inter-agency working relationships, extension agents try to ensure that other organization and community representatives and community members receive recognition for their efforts. This increases their satisfaction with the collaborative relationship and their enthusiasm for the program.

Implications

Broad-based health programming is relatively new to the Cooperative Extension Service. However, health promotion can be conducted successfully using the Extension’s program delivery and community development skills. Collaboration with health and other human service organizations can greatly enhance the extension agent’s capacity for health promotion. A Cooperative Extension Service-Health Department joint effort such as a cholesterol screening or nutrition workshop can be the foundation for more comprehensive collaboration.

Cooperative Extension Services can actively promote health and prevent injuries, disease and disability. By involving community residents in working to meet their own health and health-related needs, extension agents can help in yet another way to revitalize and improve the overall competency of rural communities.

References

Planning Local Emergency Medical Services

Gerald A. Doeken
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Local emergency medical services (EMS) may range from an advanced system with telemetry equipment to first responders with a basic first responder kit. No hard and fast rules exist to determine the appropriate level of service for a community; population, economics, and geography all present unique problems in establishing each individual system. EMS system development should remain in the hands of the local populace. As with other community problems, an advisory board should be established to help determine the level of EMS services to provide.

The Advisory Board

The advisory board should be formed so that it best represents and relates to the particular community. At least four major groups should be included on the board: providers of health services (such as physicians and other health professionals; public agencies involved with health and safety; community leaders; and consumers, who use and pay for the system). The size of the group is not as important as having members who are enthusiastic and willing to work toward the goal of planning, providing, or improving emergency medical services.

The first task is to determine the need for emergency care in the area. Need can be quantified by conducting and analyzing a survey; additional information can be obtained from records and interviews with personnel of the facilities currently providing the service. At this point, the board is ready to address the question of how to provide the service. The community may have limited funds; consequently the board’s advice on provision of EMS services must be within the community’s financial capabilities.

Before deciding on how to provide EMS services, the board must consider the contemporary practice of emergency medical care. Prior to the federal emphasis on EMS that surfaced in the mid-1960s, stress was on speed in delivering the patient to the hospital. The contemporary emphasis is on professionalism and the coordination of services to form a complete EMS system. Speed is de-emphasized while greater attention is focused on the quality of patient care at the scene of the emergency and in transit to the hospital. A contemporary system utilizes first responders, emergency medical technicians (EMTs) with various levels of training, and equipment that fulfills U.S. Department of Transportation requirements.

Alternative Levels of Service

As the board begins to evaluate the level of service to provide, it is important that they are aware of the levels of service available. The three levels include: first responder systems, basic life support systems and advanced life support systems. Each of these will be briefly summarized.

First Responder Systems. First responders provide emergency care before the ambulance arrives at the scene of an emergency. Increasingly, they are recognized as an integral part of any successful EMS system. First responders can operate in communities too small to support an ambulance and basic life support systems or in remote farming or ranching areas. A team of first responders is trained in patient stabilization and equipped with a two-way radio and first responder medical kits. When a call comes in to the EMS system, the dispatcher simultaneously dispatches the ambulance with EMTs and the first responders. The first responders arrive on the scene before the ambulance and stabilize the patient until the EMTs and ambulance arrive; hence, they often provide life-saving services. First responders are often volunteers; thus, costs, approximately $500, consist of training, a method of communication and a first responder kit.

Basic Life Support System. A basic life support system (according to a Robert Woods Johnson Foundation Special Report on EMS, 1977) is a minimum combination of the following interacting elements and personnel:

1. Informative programs for the public on emergency care of the sick and injured and how to summon an ambulance;
2. Easy and quick telephone access by which the public can obtain aid rapidly within a designated geographical area;
3. Coordinated dispatch of ambulances from the call-receiving point 24 hours a day by dispatchers trained to analyze the severity of medical occurrences;

4. A dedicated radio network that allows communication between ambulance, hospitals, physicians, and other medical and public safety resources;

5. Ambulance personnel trained in emergency procedures who can stabilize the patient at the scene and maintain that stable condition while transporting the patient;

6. Vehicles designed specifically for transport of the critically injured/ill patient and adequately equipped with life supporting supplies to sustain the patient while enroute to the hospital; and

7. Physicians in charge of all medical operations and in control of medical decisions.

All of the parts described above must be in place to form a complete, efficient EMS system of lifesaving quality. The building blocks for the system are: manpower, training, transportation, communications, and hospital facilities. This foundation is held together by cooperation and interaction at all levels of the system. As the EMS system grows, components of lesser importance and the need for their development will be recognized.

The basic life support system is dependent upon lay persons and professionals working to provide quality emergency care, 24 hours a day, 365 days a year. An adequate number of qualified, well-trained personnel are needed to make the system operate efficiently. A single administrator should be responsible for management decisions and operations.

Emergency Medical Technicians (EMTs) are responsible for on-the-scene care. This emergency care continues through transport and should, if requested, extend into the emergency room (particularly in rural areas where a physician may not be immediately available in the emergency room). EMTs are required to be trained in basic life support procedures through a standardized course. This course should be well coordinated and taught by physicians and others qualified in the specific fields covered by the course curricula. The Department of Transportation’s Basic Emergency Medical Technician course is the National Standard for basic EMT training. A minimum of 24 hours of clinical exposure in hospitals and/or ambulance services is required in addition to a minimum of 100 hours classroom work. This not only prepares neophyte EMTs for their role in street care, but also gives them an insight into hospital emergency room procedures.

Adequate emergency medical transportation has undergone a dramatic change since the inception of the U.S. Government Service Administration (GSA) KKK-A-1822 specifications for ambulances. These specifications designate requirements for performance as well as materials used for construction. Inclusion of specific patient care equipment and an interior height of 60 inches (to accommodate free movement of the EMT) are two examples of KKK-A-1882 specifications. EMS planners should make selections for new and replacement vehicles from the following three basic vehicle types:

Type I A truck chassis with modular patient care compartment fitted to the chassis and connected to the chassis with a cab window boot or a walk-through opening.

Type II A converted van with the roof raised to minimum interior height of 60 inches.

Type III A cutaway van with the driver’s cab and modular patient care compartment connected with a walk-through door.

Communication is the key to an efficient EMS system, tying the system together into a single responsive unit. The communications component should provide:

1. Toll free, 24 hour a day telephone access to a central dispatch facility through a common emergency number such as 911;

2. Alerting of ambulance crews and rescue teams through the use of telephone, pagers, or portable radios; and

3. Rapid 2-way voice communication among all elements of the system: hospitals, law enforcement agencies, First Responders, ambulance personnel, and rescue teams.

Basic life support (BLS) can be provided by a large number of alternative delivery systems. Some examples include a BLS system operating from a hospital, fire department, or police department. In small communities, costs may be reduced if EMS is provided in conjunction with another department. These systems can operate with paid or volunteer personnel. The cost of a BLS system with a paid crew will run about $200,000.1

Advanced Life Support System. Citizens soon realize that a good quality Basic Life Support system does save lives. This becomes obvious through newspaper stories, television and word of mouth. As
this realization occurs, progressing to an Advanced Life Support (ALS) system provides even more lifesaving opportunities.

In moving to an ALS system, the delivery of emergency care is refined; manpower, communications, transportation, facilities (critical care designation) and medical control are upgraded. Manpower and training change the most dramatically of any of the components when the system moves toward ALS. EMTs licensed at advanced levels—advanced, advanced cardiac, and paramedic—must be available for ALS to function. Rural areas will find it more difficult than their urban counterparts to establish a viable ALS, but it can be done.

Provision of more life saving equipment associated with ALS will often increase the costs of EMS by more than $15,000. The greatest annual expense is increased labor costs of advanced personnel.

Alternative Revenue Sources

The EMS advisory board will also need to evaluate revenue sources, which may vary from state to state. Some sources include user fees, special taxation districts, sales taxes, public utility assessments, and county or city subsidies. The advisory board must estimate how much can be generated from each source, decide on the desired source of revenue, and plan their EMS system.

Summary

Once an EMS system is in place, an advisory board needs to continue to function. In order to maintain and improve the quality of care, constant evaluation by the advisory board is needed. In addition to the planning function discussed above, the advisory board can play a major role in public relations. The public must be informed to understand the complex nature of EMS. With this knowledge, the public will support the efforts of the advisory board and EMS system.

PLANNING LOCAL EMERGENCY MEDICAL SERVICES

Questions to ask

I. Does your community have a local advisory committee? Yes or No

II. If you have a committee, are the following interest groups on the committee?
   A. Health providers
   B. Public agencies
   C. Community leaders
   D. Consumers
   E. Elderly
   F. Minorities

III. Have emergency medical service needs been studied?

IV. Could your community benefit from:
   A. A first responder system?
   B. A basic life support system?
   C. An advanced life support system?

V. What are your delivery alternatives and costs?

VI. What are your revenue alternatives and amounts?

Options for Restructuring Hospitals

Margaret M. Moore
Louisiana Cooperative Extension Service

Financial Plight of Rural Hospitals

The financial plight of rural hospitals throughout the United States is affected by a combination of rapid change in the rural economy and national efforts at medical cost containment. Many rural communities are both economically depressed and losing population. Weak economies with the decrease in rural employment result in a higher percentage of rural residents without health insurance. This results in rural hospitals having to increase amounts of indigent care and bad debt. The rural depression reduces the amount of public support for rural hospitals from taxation and donations.

From 1980-85, almost one-third of the nation’s hospital closures were in Arkansas, Louisiana, Texas and Oklahoma alone. The increase in hospital closures relates closely to Medicare’s implementation of the Prospective Payment System (PPS) in 1984, with more than twice as many hospitals closing in 1987 as in 1984. Under PPS, Medicare pays rural hospitals 36 percent less than urban hospitals for the same services. As a result, according to the Department of Health and Human Services, in 1986 urban hospitals made a 10.82 percent profit margin on PPS patients, while rural hospitals lost an average 0.69 percent.

Hospital Closures in the U.S.*

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*American Hospital Association

Importance of Rural Hospitals to Rural Economy

The importance of rural hospitals in the rural economy extends beyond health care to the community. In many communities, the hospital is one of the largest employers. Because rural hospitals are labor-intensive, they provide jobs and, through the multiplier effect, represent a significant economic resource. Thus, the investment in capital and in human resources in a rural hospital often represents a basic investment in the rural community. An economic forecasting model applied to a seven-county area projected that the closure of a single rural hospital would cost the regional economy more than $100 million and 8,000 jobs in the seven-year period studied. A Department of Commerce model, when applied to rural hospitals, estimates that for every full-time equivalent job in a rural hospital, .587 jobs in the local economy are created through the multiplier effect.

Reasons for Restructuring Rural Hospitals

What are the reasons for restructuring rural hospitals? One of the greatest problems rural hospitals face is the outmigration of rural residents to urban areas for care. Studies suggest that rural residents (especially young and affluent residents) leave their communities, either to obtain specialized care not available locally or to obtain alternatives to locally available services.

Another reason to restructure rural hospitals exists because of the absence of federal Medicare support to cover the fixed costs of maintaining rural hospital beds. State governments should not simply provide the needed financial support to maintain the present hospital delivery structure. States should encourage rural hospitals to restructure to meet the needs of rural residents. Hospitals can either enhance their revenue to meet costs by providing more appropriate services to the community or lowering their fixed costs by developing shared services with other providers. States can help rural hospitals by establishing policies that facilitate both.
Community Needs

Specific health care needs vary according to each community. In general, rural residents are most in need of basic obstetric and perinatal care, pediatric care, nursing home and home health care for an aging and disabled population, emergency medical services and limited inpatient services. Another study indicates rural residents are more likely to suffer from chronic disease conditions, including arthritis, visual and hearing impairments, ulcers, thyroid and kidney problems, heart disease, hypertension and emphysema. They are also more likely to suffer limitations in activity as a result of these chronic conditions than are urban dwellers.

Rural statistics on homeless individuals are inadequate, but rural data on substandard housing, unemployment rates, employer and business failures may indicate that homelessness is not a predominately urban problem. One study indicates that nonmetropolitan areas have an estimated 18 percent of all homeless people but have received only 10 percent of the grants.

Centers for Disease Control (CDC) statistics indicate that rural areas face a growing problem which will further tax their limited resources because data indicate that 20 percent of AIDS cases are rural. Currently, these victims must move to urban areas for treatment and abandon their existing social support systems.

Given the nation's ongoing dependence on migrant and seasonal labor, rural America will continue to face this problem and will need to deal more effectively with access to existing services as well as the problem of care in areas which do not now have migrant health programs. Moreover, general problems of access to health care in rural areas are intensified for minorities (blacks, hispanics) and special population groups as for the elderly who are unable to pay. Consideration of rural health problems must involve discussions of both patient issues and provider/resource availability.

Rural communities are forced by scarce resources to choose between necessary services. In very small communities or sparsely populated areas, the people may be forced to do without health services altogether.

Ideal Rural Health Care System

The ideal rural health care system of the future would include primary-care practice, an emergency room with short-term stabilization beds and a few acute care beds for less complicated cases, home health services and nursing home beds for post-hospital care, long-term supportive services for the frail elderly and collaboration with urban and university medical centers. Currently, federal laws make this impossible. State governments can facilitate the restructuring of rural hospitals by developing policies that encourage hospitals to reduce their reliance on oversupplied acute care services and to develop services that more appropriately meet the needs of their communities. In addition, certificate-of-need rules could be revised to facilitate positive change.

Assessment of Health Care for Rural Residents

To quickly assist local community leaders in evaluating rural health care services, circle one response.

| Primary Care (ambulatory care) | Adequate | Inadequate |
| Home Health Services | Adequate | Inadequate |
| Modern Ambulance and EMT (emergency medical technicians) | Adequate | Inadequate |
| Hospital emergency room | Adequate | Inadequate |
| Secondary Care | | |
| - short-term stabilization care beds | Adequate | Inadequate |
| - few acute care beds | Adequate | Inadequate |
| - nursing home beds for posthospital care | Adequate | Inadequate |
| - long-term supportive services for frail elderly | Adequate | Inadequate |
| Linkages with urban and university medical centers | Adequate | Inadequate |
| Financial support for all above services | Adequate | Inadequate |
| Residents informed about local care available | Adequate | Inadequate |

Discuss the inadequacies with your local professionals, hospital administrators, community leaders and Congressmen to start improving local rural health care.

Since 1983, rural communities and hospitals have been exploring survival options. These fall under three approaches to increase hospital revenue and decrease costs: develop individual strategies to increase revenue, develop linkages between urban and rural hospitals to form a multi-hospital system, or develop networks or rural hospitals to share services to create a more efficient system.

State policy efforts should encourage the development of the rural health system of the future. The ideal health system may contain the following components:

- The ability to respond effectively to emergencies that occur in rural communities.
* The ability to stabilize and transfer patients who have conditions that require technological intervention beyond the capability of rural hospitals.

* The ability to deliver comprehensive primary services that are effectively linked to secondary and tertiary care.

* The ability to provide appropriate services to rural elderly that encourage cost-effective community-based care and allow the frail elderly who need institutionalization to receive care within their own communities.

Restructuring efforts are generally premised on three assumptions: there is an excess of acute care beds in a given community; the level of demand is not adequate to maintain existing services under the current prospective payment system; and rural patients are traveling away from their communities to receive services. A careful analysis of projected costs and revenues is needed for each proposed new service, as well as the projection of the likely demand for the service in the community.

One of the key policy tools a state can use to reshape the marketplace to encourage appropriate restructuring is its state Medicaid program. Medicaid accounts for about 10 percent of rural hospitals' business. Another Medicaid advantage is that it is a federal matching program.

Nursing Homes

The development of hospital-based skilled nursing facilities (SNF) in a rural hospital is a diversification strategy often appropriate to the needs of rural residents. Rural elderly in need of nursing home care is increasing. The supply of nursing home beds in rural areas is often insufficient. (Oversupply tends to be concentrated in suburban communities.) Frail elderly who are functionally impaired can receive care in their own community.

Physician Shortage and MLPs

Despite an oversupply of physicians nationally, most of rural America still has a physician shortage. It may be appropriate now to increase the use of mid-level practitioners (MLPs)—physicians' assistants, nurse midwives and nurse practitioners—in rural areas. Two obstacles to the MLPs have been the inability to receive Medicare and Medicaid payments and to obtain hospital privileges because of state licensing and certification restrictions.

Permitting RNs and LPNs to Dispense Prescription Drugs

Permitting registered nurses (RN) or licensed practical nurses (LPN) to dispense prescription drugs on an outpatient basis is another way states can improve access to needed services and facilitate rural hospital survival. Few states allow nurses to dispense prescription drugs on an outpatient basis, but it is universally acceptable in an inpatient setting. For a rural hospital without a full-time pharmacist, a state could certify (through its Nurses' Practices Act) nurses to dispense pharmaceuticals, thus simplifying patients' compliance with prescribed treatment and creating an additional reimbursement that benefits rural hospitals.

Cross-Training and Cross-Certification of Technicians and Technologists

Another mechanism states can use to facilitate cost-effective care in rural communities is to encourage the cross-training and cross-certification of laboratory and radiology technicians. Rural hospitals are often required to have two separate individuals scheduled and on-call, when one cross-trained technician would be sufficient.

Approximately 14 states now allow physical therapists (PTs) to see patients directly without referral or supervision of a physician. The increased independence for ancillary practitioners primarily benefits rural communities and rural hospitals. To qualify for direct access, practicing in a hospital is often required. This requirement facilitates the rural hospital's role as the focal point of care.

Computer Links

Computer links can bring the latest technology to remote rural hospitals. The revolution in computer and communications technology holds new promise for affording rural health care providers an immediately responsive link with the finest resources the medical world has to offer, if they have the resources to become educated and are equipped to plug into that network.

State governments can greatly facilitate the efforts of rural hospitals by creating state administrative offices, by supporting state data banks, and by providing state technical assistance to encourage and support the formation of rural networks.

Multi-hospital Systems

Some rural hospitals change their organizational relationship to multi-hospital systems to promote their survival.
State governments need to consider these issues in the development of multi-hospital systems:

* Assure that local tax dollars directed toward a specific facility are appropriately used in the multi-hospital system;

* Assure that "sunshine laws" and other requirements of public input in decisionmaking are appropriately treated in a multi-hospital system; and

* Assure that acquisition by a multi-hospital system is structured to assure the long-term interests of the rural community whose facility has been acquired.

Summary
In summary, services needed in rural areas are in short supply. While reducing the number of acute care beds, hospitals can be restructured to provide skilled nursing care in lieu of placing the elderly in nursing homes far from their families and friends. Using hospital space and facilities, physicians' assistants and nurse practitioners can provide basic primary care to compensate for the lack of physicians in many rural areas. Home health care and long-term in-home supportive care for the frail elderly are also needed in many communities. Restructuring would also enable the rural hospital to better fill one of its most basic missions - emergency care. All of these options are avenues to restructuring a hospital's services to meet the community's needs and to improve hospital revenue. The key issue here is that, to survive and continue providing needed services, a hospital must be able to cover its fixed costs.

Although rural hospital revenues from Medicare are likely to improve, it is unlikely that Medicare payments will cover the fixed costs of rural hospitals. Thus, if rural hospitals are to remain open, they must develop other services besides acute care. States seeking to facilitate the restructuring efforts of rural hospitals will need to consider possible changes in a variety of state policies and programs, including certificate-of-need guidelines, licensing and certification (both of facilities and of individuals), Medicaid reimbursement and hospital capital pools.

It is easy to set aside our concerns about access to quality health care. We have so many demands that claim our attention and time. But, leaving such a concern to await a crisis is to ensure that such a crisis will occur.

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Physician Recruitment and Retention: a Community Effort

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Many community leaders have realized over the past several years that resources from the federal and state levels have dwindled. Community leaders must now rely more on their own resources and their own initiative to solve their problems. One of the major needs facing some communities is physicians. There are many barriers to face and overcome, and bridges to cross before communities find success in recruiting a physician to their community. This article attempts to bring to mind some thoughts regarding the who, how and what regarding the recruitment of physicians. This article is not so comprehensive that it answers every question about the recruiting process, but it may shed some light on the subject at hand.

Situation

The supply of physicians may be less a question of concern than the distribution of physicians. Even though there has been an increase in the total number of physicians in the last decade, rural areas lag behind the metro areas in the physician-to-population ratio. In the rural areas (non-metro counties), there are 91 physicians per 100,000 residents, compared to metro counties with 216 physicians per 100,000 residents. In non-metro counties with population under 10,000, there are only 48 physicians per 100,000 residents (see Figure 1). To further emphasize the maldistribution of physicians, there are 100 counties in the U.S. that have no practicing physicians.

Rural communities have less physicians to recruit and greater competition. The primary care physicians (general/family physicians, internal medicine, ob/gyn and pediatrics), are the cornerstones of rural health care. The supply of these physicians is decreasing because many physicians are now specializing. In addition to the decreasing supply of primary care physicians, rural communities also face increasing competition from Health Maintenance Organizations (HMO), which are based in large urban centers and employ primary health care physicians. Health Maintenance Organizations provide basic health care services for a fixed fee rather than a fee for service.

Rural areas are also threatened by the possible loss of physicians due to the age of the rural physicians. Rural physicians make up only 12 percent of the total number of physicians. Of those 12 percent, there are approximately 25 percent that could retire within the next five years (1989-1994).

For rural communities, recruiting and retaining physicians may be the most difficult and long term task. Recruiting physicians is probably as difficult, if not more difficult, as recruiting industries. Recruiting physicians, like industrial recruitment, has to be an ongoing process of assessing, planning and implementing strategies that will eventually achieve the goal.

Who Should Recruit?

Industrial recruitment is often the responsibility of the Chamber of Commerce or the Industrial Development Authority. Who is responsible for recruiting physicians? Often this task is left to the local hospital or other physicians in the community. The more profitable hospitals may hire a consultant to recruit new physicians. Some hospital administrators may do the recruiting in addition to their other responsibilities. There is certainly no specific community-based organization, like the chamber or industrial authority, responsible for recruiting physicians.

If your community and/or county has no hospital, then who might be responsible? Recruitment may fall to the local physician; however, rural
physicians are already overworked and can find little time to recruit. If no one within the health arena is recruiting on a full time basis, the responsibility may fall to the local chamber executive or to local governmental officials or, in some cases, there is no one recruiting physicians.

Recruiting physicians should be as broadly based as possible, especially when it comes to a marketing strategy. It is important to remember that physicians live, as well as work, play, and raise families in the community. Developing a recruitment strategy or package is an important first step. Developing such a package may be best accomplished via a committee that represents both the major health care providers and community leaders. From the health community, committee members may include the hospital administrator, director of nursing, another physician, a staff nurse or a public health nurse. Other committee members may include a realtor, a banker, a lawyer, Chamber of Commerce director or president, and a local governmental official. Regardless of who does the actual recruiting, it is important to develop a marketing package that includes not only the attributes and offerings of the medical community, but also those of the community at large.

Assessing Your Chances

There are many questions to answer and barriers to overcome before a community embarks on the recruitment effort.

Do you need a physician? If you already have a physician you should determine an estimated time of retirement. Don't wait to begin recruiting after the physician announces retirement. Even if the physician is not ready to retire, the physician in the community needs to be involved in the recruiting effort and kept informed. A physician will not locate a practice in the community without an acknowledged acceptance by other physicians and medical providers in the community.

Is your community too small? Counties with populations of less than 10,000 people will probably find it more difficult to obtain a physician than larger counties. Physicians need a population base large enough to support a practice. Some counties with small populations may qualify for federal and state assistance, if it is a Health Professions Shortage Area. This will be discussed in more detail below.

Is your community too isolated? Isolation may mean more than just the distance from a metro or large urban center. Communities without the latest medical technology may also be considered in isolation. Many rural hospitals, which are under economic stress, can ill afford all the up-to-date medical technology. Computer and satellite technolo has done much to alleviate isolation communities. Such technology can bridge between the local hospital and other medical that have more resources. Investing in such equipment may help the local hospital st competitive in the physician market.

Marketing Your Community

There is no one strategy or package of that guarantees a community a physician. A appeal to one physician may not appeal to Communities must be honest in what they c a physician to move to their community. Crties can ill afford mistakes and unwanted pu

In your community willing to guard annual salary of $90,000, or even $125,000 Even this does not guarantee you will find One community offered a reward of $10,000 to M. D., which was cheap—if it had worked. Communities without a hospital may difficult, if not impossible, to recruit suc However, this depends on how close a hosp be to the community. Having a hospital away in the next county should be of less than having one farther away. Communities commuting distance (one hour or less) from a still may have a chance to recruit a ph

Obviously, the community without a hospital a physician must have a working relationship nearby hospital and medical community. Communities than ever are now working to recruit a physician.

Communities recruiting physicians m take a more in-depth look at the new physician's spouse. The spouse's career is a tant factor in the decision making process. time communities just needed to be concern whether the spouse liked the schools, church, local retail stores, but this is no longer the addition, don't assume the spouse is female and more physicians are female and their l are looking for career opportunities.

Communities need to be prepared to physicians leisure time. Therefore, recruit one physician for a solo practice in a com difficult. In addition to the need for lea physicians are looking for time away from community for professional development.

Communities have also been willing physicians in the early stages of their pr offering free office space and providing sup and services. In addition, communities have to pay malpractice insurance.

The marketing package should be spe general. Already-prepared contracts and ag
committed to working in these areas. There were many such physicians practicing in rural communities in the 80s, but lack of funding for the program has significantly reduced the number of physicians that will be available to practice in rural areas. However, efforts are underway to restore the program and the funding. In addition to the NHSC scholarship, a federal loan repayment program is available through the state governments on a 50:50 match. The program pays from $25,000 to $35,000 a year of a physician’s educational debt for each year of service in an under-served area. Unlike the more structured NHSC program, physicians can be recruited upon completion of medical school, and physicians with specialties may be recruited.

Other Options

Let’s face facts—some small rural communities will face almost insurmountable obstacles in their effort to recruit a physician. For some communities, mid-level health professionals may be the best alternative. Mid-level health professionals include nurse practitioners, physicians assistants and nurse midwives. For many mid-level professionals, various states have set limits on the ability of these professionals to practice independently of a physician. Mid-level professionals usually work under the supervision of a physician. In some cases, states may require them to practice under the same roof with the physician. Be familiar with the state requirements concerning mid-level professionals. If you choose to seek mid-level health professionals, remember they are paid much less than physicians. To be more effective in recruiting a mid-level professional, a community may be more compelled to secure employment for a spouse in order to insure the financial survival of the family.

Federal and State Assistance

Your community may be designated as a Health Professional Shortage Area if your community meets certain criteria. The criteria for designation usually begins with the number of primary care physicians per population ratio; 3000:1 for a high need, and 3500:1 for a low need. There are other conditions such as infant mortality, high fertility rate, poverty rates, insufficient capacity of existing primary health care physicians, special populations, health care facilities, and others that may exist in the service area that may add to the dimension of need. For further information, contact the State Health Regulatory Department or the Governor’s office.

If your community is within this designated area, you are eligible for assistance. In the past, medical students who had received a scholarship from the National Health Service Corporation (NHSC) were
Checklist

Listed below are some questions that may need to be answered in recruiting and developing a marketing package for the recruitment of a physician.

1. Is the medical community in support of your recruitment effort?

2. Who is recruiting (local personnel or a hired consultant)?

3. If a consultant is hired to recruit a doctor, will he find you a doctor, or just provide you with names? Be specific in your contract with consultants.

4. Do you have an adequate budget to recruit (advertising budget, mass mail budget, candidate travel, promotional materials)?

5. Have you prepared promotional materials that adequately describe the health facilities in your community?

6. Are you willing to guarantee a salary? If so, how much?

7. Are you willing to provide office space for free, or at a reduced cost, to assist a new physician?

8. Are you willing to provide support staff at a reduced cost or at no charge? If so, for how long?

9. Are you willing to assist a physician's spouse in locating job opportunities? If so, for how long?

10. Are you willing to pay malpractice insurance for the physician and for what period of time?

11. Are you prepared to market your community (educational system, public and private services, business and industry, recreational facilities)?

12. Is your community eligible for any federal or state assistance?

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Recruitment and Retention of Nursing Personnel in a Rural Area

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Rural areas in America today are faced with many issues when it comes to health care. Among these are reimbursement restrictions, keeping small hospitals in operation, ensuring access to emergency services, and recruiting and retaining necessary personnel. This article is intended to offer some possible solutions to the recruitment and retention of nurses (RN - Nurse Practitioners) in rural areas. It is not intended to be a means to all ends.

According to the Secretary’s Commission on Nursing (1988), over 9 percent of rural hospital beds were closed in 1988 because of a shortage of registered nurses. Among rural hospitals that permanently closed their doors in 1988, 75 percent reported substantial to severe nursing shortages. Rural areas have 24 percent of the nation’s population and only 18 percent of the nation’s nurses. In addition, 14 percent of the nurses residing in rural areas commute to work in an urban facility (Secretary’s Commission on Nursing, 1988). Also, the average rural nurse is older than his or her urban counterpart. Sixty-six percent of all rural employed nurses are under the age of 44 compared to 70 percent of urban employed nurses. The nursing shortage also occurs at a time when an increased incidence of chronic illness and highly sophisticated technology have nearly doubled the staffing patterns of nursing from an average of 50 registered nurses per 100 patients in 1972 to 96 registered nurses per 100 patients in 1986.

While gathering information for this article, several local agencies (hospitals, nursing homes, home health) were contacted. The directors of nursing were the contact persons. Although none had written policy and procedures for nurse recruitment, most had some “undocumented” strategies. One agency said they contact the local school of nursing. Another said they use word-of-mouth, friend of a friend, and hiring nursing students in other capacities in the hospital in hopes they will return upon graduation. Other agencies have utilized various staffing patterns. One agency makes contracts with nursing students to pay tuition and purchase books in return for commitments upon graduation. This same agency also provides monies for continuing education. Another agency was quoted as saying, “We do not turn any nurse away.” Local media, like newspapers and TV, are also used to recruit.

The Mississippi State Nurses’ Association and the National Nurses’ Association were contacted. Neither has any written policies and procedures for nurse recruitment and retention in rural area.

In a study done by Stratton, Juhl, Dunkin, Ludtke, and Geller (1990), the following statements reflect some of their findings regarding recruitment and retention of registered nurses for hospitals and nursing homes: hospital directors of nursing reported less success than nursing home directors in utilizing increased salaries and benefits to recruit RNs, although they did report having slightly greater success with short-term rewards such as relocation assistance, sign-on bonuses, and recruitment bonuses. In terms of formalized recruiting, long-term care facilities relied much more heavily upon media advertising than hospitals and about the same as hospitals on word-of-mouth. The most apparent difference in incentives used by hospitals and long-term care facilities is that of educational-related benefits (paid CEs, in-services, tuition reimbursement) which were cited most frequently by hospitals and least by long-term care facilities.

In terms of barriers, salaries and benefits were perceived as a recruitment barrier by a greater percentage of directors of nursing of long-term care facilities, 35.2 percent versus 20.3 percent by directors of nursing of hospitals. Twelve percent of directors of nursing of long-term care facilities felt the image of long-term care nursing was a major deterrent to RN recruitment. Ironically, as some hospital directors of nursing reported some success in stressing the rural qualities of their environment in recruiting RNs (low crime, family orientation, close personal integration), others were reporting these same factors to be barriers to recruitment because of the geographic locality and community-related factors (lack of social amenities, housing, etc.). There was very little difference in the two regarding impacts of
the local nursing supply or the lack of resources on their ability to successfully recruit RNs.

Retention strategies correlated to recruitment strategies very closely. Educational opportunities were clearly the most distinguishing types of retention strategies. Continuing education, tuition reimbursement, flex time, and certification based wage differentials were more prevalent in hospitals. Only in educational-based wage differentials did long-term care facilities report greater usage. In terms of career ladders, both reported about the same usage. Both settings also used self-worth and self-esteem incentives as a retention strategy, such as, planning policies and procedures and programs of patient care.

Responses to the Rural Health Care Deliveries

To maintain financial integrity, access to care, and health care personnel, rural delivery models have developed. Many of these models rely on the involvement of community leaders to help evaluate local health care demands and design responsive systems. More rural communities and health care systems may need to integrate rural hospitals with other health care facilities in the community or region. Some rural hospitals are evaluating the appropriateness of continuing as full-service facilities. Hospitals within certain regions may eventually specialize in selected services in order to decrease duplication and cost.

Most public institutions of higher education have a mission to meet the needs of their states, and most states have a significant rural population. Thus, many of these schools have an obligation to address rural health care in their curricula. For states with substantial rural populations, nursing, medicine, psychology, social work and other disciplines should be at the drawing board developing curricula that target positive experiences in rural areas.

State level responses are also needed to resolve the crisis that has hit rural American. In 1988 the National Governors' Association recommended that states enhance flexibility in licensing and reimbursement in order to deal with the rural health personnel shortage. The NGA also recommended states review licensing and certification requirements for health care facilities to assure that maximum flexibility is available to rural health care facilities while quality of care is protected.

Concern for rural health care is growing and is evident; in fact, more than twenty states have established state offices of rural health. When possible, states should appropriate monies to educate health care providers for rural employment. However, given the lean economy of many rural states, the likelihood of significant funding designed to improve health care facilities or increase providers in rural areas is rare at best.

In acknowledgement and recognition of the health care needs of rural American and the poor health care service, the federal government accelerated its responses to a host of rural health care problems. In the first session of the 101st Congress, over 25 related bills were introduced. Those bills would:

1. Enhance coverage of nurse-midwifery services through Medicaid.
2. Set aside money for National Health Service Corps scholarships and loan repayments for nurse practitioners who agree to serve in health manpower shortage areas.
3. Give priority to applicants for the NHSC scholarship program who plan to attend institutions that provide rural training opportunities.
4. Provide four-year grants to 10-15 hospitals that plan to change from rural hospitals to medical assistance facilities. Medical assistance facilities provide emergency care to victims enroute to larger regional hospitals.
5. Directly reimburse nurse practitioners and clinical nurse specialists in rural underserved areas.
6. Provide a higher prospective payment update factor for rural hospitals.

Appropriations for FY 90 were increased over 1989 levels for a number of federally sponsored rural health care programs; one being nurse training which includes programs for educating nurse midwives, nurse practitioners, and nurse anesthetists; a second being interdisciplinary training projects in higher education that use innovative methods to educate health care practitioners to provide services in rural areas. Projects are supported that attempt to increase the recruitment and retention of rural health care providers. Some funds may be used to support student stipends and faculty training.

For individuals interested in contemplating bold solutions to new problems, rural health care provides a fertile ground. New health care delivery mechanisms in rural areas are being explored. As costs, quality and access to health care remain high priority items, new trends may be set in rural areas in terms of nursing practice and reimbursement.

Certainly, there are no one-answer solutions to the problems of sufficient nursing personnel. It seems the more an agency or community has "going
for it" the least likely it will suffer a nursing personnel shortage. The following page contains a partial listing of items to consider when attempting to recruit and retain nursing personnel.

References


Communities and Employment Agencies of Health Care Personnel

Need to Consider all or Part of the Following in Planning to Recruit and Retain Nurses

**CHECKLIST**

FOR COMMUNITIES

How would you rate the community with regard to:

1. Nice area to live
2. Safe childrearing atmosphere
3. Good area for purchase of home
4. Appropriate worship services
5. Ample social opportunities

6. Professional employment for spouse
7. Investment opportunities
8. Local school of nursing
9. Good geographic location

**CHECKLIST**

FOR HEALTH EMPLOYMENT AGENCIES

How would you rate employers health care providers in regard to:

1. Career ladders
2. Continuing education
3. Flex time
4. Wage differentials based on education, certification or qualifications
5. Salary

6. Benefits
7. Employer reputation
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